STATE OF TENNESSEE

DEPARTMENT OF FINANCE AND ADMINISRATION

BUREAU OF TENNCARE

REQUEST FOR INFORMATION

FOR

MANAGED CARE ORGANIZATION SERVING

MIDDLE TENNESSEE REGION

RFI NUMBER: 318.65-217

Submitted by Windsor Health Plan of TN, Inc.

December 12, 2005

CORPORATE BACKGROUND AND EXPERIENCE

1. **Corporate Information**

Windsor Health Plan of TN, Inc.
d/b/a VHP CommunityCare
7100 Commerce Way, Suite 285, Brentwood, TN 37027
PH: 615-782-7800
FAX: 615-782-7812
mbailey@vhptn.com

2. **If a subsidiary or affiliate of a parent organization, corporate information of parent organization**

Windsor Health Group, Inc.
7100 Commerce Way, Suite 285, Brentwood, TN 37027
PH: 615-782-7910
FAX: 615-782-7812
phertik@windsorhealthgroup.com

3. **State of incorporation or where otherwise organized to do business**

Both Windsor Health Plan of TN, Inc. and Windsor Health Group, Inc. are Tennessee corporations.

4. **States where currently licensed to accept risk and a description of each license**

Windsor Health Plan of TN, Inc. (WHP) holds a Certificate of Authority as an HMO serving TennCare enrollees in Davidson County and serving Medicare enrollees in Tennessee in counties certified by the federal Centers for Medicare and Medicaid Services, currently Shelby, Tipton, Fayette, Madison, Cheatham, Davidson and Williamson.

5. **Contact Information:**

Michael D. Bailey
President & Chief Executive Officer
PH: 615-782-7879
FAX: 615-782-7812
mbailey@vhptn.com

6. Program Experience—General

a) Do you have at least three years Medicaid experience under capitation? If yes, please identify the states and contract periods. If no, do you have at least three years of experience under capitation in another market?

Windsor Health Plan of TN, doing business as VHP CommunityCare, has operated as a contracting MCO within the TennCare program since the inception of the program and operated successfully under risk from January 1, 1994 until June 30, 2002. WHP also has significant experience in managing within a capitation environment in both the Medicare and commercial risk environments. In addition, the senior management of Windsor Health Plan of TN has previous direct experience in Medicaid risk contracting in the states of Florida, Missouri and Pennsylvania.

b) Are you currently accredited by NCQA for your Medicaid product line? If no, are your or any other plans operated by your parent or affiliate NCQA accredited? Which product lines? Would you be willing to become NCQA accredited within a reasonable period of time after contract award? Do you have experience with HEDIS and CAHPS? Please explain.

WHP is currently seeking NCQA accreditation as required under the current TennCare Contractor Risk Agreement. WHP has a well-developed quality management program which has enabled it to achieve EQRO scores of 97%, 94%, and 98%, over the most recent three years, respectively. WHP is experienced in HEDIS measures and has utilized a modified CAHPS survey each year. Our current survey is fully CAHPS compliant.

c) Do you currently contract with any State to provide Medicaid services? If yes, proceed to question 7. If no, proceed to question 10.

Yes, Tennessee

7. Medicaid Program Experience – Services

Using the list below, please provide a chart that indicates for each of the states where you currently contract: 1) whether you provide the service; and 2) whether you provide the service directly or through a subcontract arrangement.

Service	Provided	Direct or Subcontract
Physical Health Benefits	✓	Direct
Dental Benefits		
Vision Benefits	✓	Partial Subcontract
Non-Emergency Transportation	✓	Subcontract

Behavioral Health Benefits		
Pharmacy Benefits		
Long -Term Care Benefits		
Home Health	✓	Subcontract through affiliate
Claims Processing and Adjudication	✓	Partial Subcontract
Quality Assurance	✓	Direct
Utilization Management	✓	Direct
Case Management	✓	Direct
Disease Management	✓	Direct
Provider Credentialing	✓	Direct with partial delegation
Enrollment Assistance		
Member Services	✓	Direct
Member Grievances/Appeals	✓	Direct

8. Medicaid Program Experience—Population

Using the list below, please submit a chart that includes for each of the states where you currently contract: 1) the population(s) served; and 2) the approximate number of individuals served in each population.

- **Aged, Blind and Disabled – excluding dual eligibles**
- **Dual Eligibles: individuals eligible for both Medicaid and Medicare**
- **TANF and TANF-Related**
- **SCHIP**
- **Waiver Expansion Population (low-income uninsured)**
- **SPMI (Seriously and Persistently Mentally Ill)**
- **SED (Seriously Emotionally Disturbed Children/Youth)**

As of October, 2005 WHP served the following numbers of TennCare enrollees in the specified categories.

Medicaid (TANF and TANF-related)	32,063
Disabled	3,189
Dual eligible	4,600
Uninsured and Uninsurable	1,709
	41,561

9. Medicaid Program Experience - Payment Methodology

Please submit a chart that indicates the payment methodology for each state contract, specifically addressing the risk methodology, e.g., full-risk, partial risk, shared risk, etc. Please also describe any financial incentives you currently participate in, including the applicable service(s) and the measures.

Payment methodology and shared risk/incentives are in accordance with the current TennCare Contractor Risk Agreement.

10. Experience—Former Medicaid and/or Commercial

If you currently do not contract to provide Medicaid program services, but have in the past, please provide a brief description of the services you provided and the populations you served. Please also indicate the dates of your previous Medicaid contract(s), and indicate the state you contracted with to provide Medicaid services. If you have never contracted to provide Medicaid services, please provide a brief description of the services you provide and the populations/markets you serve.

WHP currently provides Medicaid program services in Tennessee.

11. Reformed Managed Care Model

A. Behavioral Health

1. **Is your organization currently responsible for providing behavioral health services? If yes, in what state Medicaid programs? Please describe the services you provide and to what populations. Please specify if you serve individuals with serious emotional disturbance (SED) and/or individuals with severe persistent mental illness (SPMI). Please also specify whether you provide these services directly or whether you use a subcontract arrangement. If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured. How/who handles member/provider services, appeals, claims, etc.? How is the subcontractor paid?**

For purposes of providing behavioral health services to TennCare enrollees in the Grand Middle Region, WHP has entered into a letter of intent to partner with Advantage Behavioral Health, Inc., (Advantage) a wholly owned subsidiary of Centerstone Community Mental Health Centers, Inc. WHP has elected to partner with Advantage for a variety of reasons, but most importantly for the following. First, Centerstone is the dominant behavioral health provider in Middle Tennessee with 61 facilities in 21 counties

and has significant experience managing the care of TennCare enrollees with behavioral health conditions. Second, WHP-Advantage will develop an integrated management system; whereby, WHP's technology and systems platform will be used for both medical and behavioral managed care purposes. Third, both management teams recognize the merits of integrated care, and seek to address the shortcomings of the current carve out model - inadequate care coordination, less than optimal outcomes and disincentives regarding disease management practices. WHP-Advantage together possess the knowledge, expertise and commitment to transition to an integrated managed care model that treats the person's total healthcare needs and eliminates the artificial separation of mind and body.

Over the eleven year life of the TennCare program, WHP has provided services to individuals of all ages and behavioral health diagnoses in tandem with the Vanderbilt University Medical Center. In the early years of the program, the health plan managed behavioral health services directly for the non-priority TennCare enrollees (those not considered severely mentally ill or seriously emotionally disturbed) and its performance was considered to be well within the expectations of the State's contracted risk arrangement.

The advent of the TennCare Partners Program in June 1996 added individuals designated as SPMI (severely and persistently mentally ill) and SED (seriously emotionally disturbed) to the eligibility file which brought new management challenges. As access to behavioral health services via the current TennCare BHO's resulted in inadequate care coordination, a significant amount of mental health care was rendered by the medical network of pediatricians, internists, gerontologists and other medical specialists.

Through our partnership with Advantage, WHP gains the Advantage expertise in specialized public sector behavioral health managed care, including vast experience in the treatment of behavioral health disorders with a specific focus on the SPMI and SED enrollee population.

The partnership forged by WHP-Advantage represents a powerful combination of medical and behavioral health management expertise in this era of reformed managed care. At a time when providers and other healthcare-related organizations are being asked to stretch resources as far as possible, the availability of information for the coordination of clinical decisions and the ability to eliminate redundancy and create administrative efficiency is more critical than ever. A system of integrated behavioral and medical care will reduce waste and inefficiency and result in better patient follow-through, optimize outcomes, and produce greater satisfaction for patients and providers. The partnership goal is to create a combined medical and behavioral health network and administrative infrastructure with the intention that regardless of the primary presenting condition, the TennCare enrollee will find accessible care and health outcomes delivered within a recovery-oriented approach.

The following administrative functions represent examples of areas of coordination across the two business entities:

- Member and Customer Services
- Medical and Clinical Management
- Appeals and Grievances

- Network and Provider Relations
- Claims Management
- Information Technology and Reporting

WHP-Advantage is committed to creating a subcontractor reimbursement arrangement that aligns financial incentives and desirable healthcare outcomes across the management structures of the medical and behavioral health organizations. Foremost to the partnership is a shared vision and determination to succeed at every milestone including fulfillment of the performance standards as set forth by the TennCare contract.

2. Please describe your medical management model for care coordination and service integration between behavioral health providers and physical health providers, in particular an individual's primary care provider. Please describe your experience with ethnically and racially diverse populations in physical health and behavioral health settings.

As true alliance partners, WHP-Advantage will implement a comprehensive, shared utilization management plan and medical/clinical management model. The WHP-Advantage integrated medical management model is predicated on a number of key principles:

- Develop avenues for linkage and coordination across all providers and systems of care from preventive strategies to long term care services
- Focus outreach and prevention strategies on early intervention
- Focus resources in disease and care management strategies on high risk conditions and enrollees
- Ensure collection of accurate, comprehensive encounter and outcomes data for delivery system-wide quality improvements
- Manage to meet/exceed performance goals and fiscal targets

WHP-Advantage, because of their substantial involvement with the TennCare population, are experienced with racially and ethnically diverse populations and their network includes experienced professionals with knowledge and expertise in the community based on the ethnic, racial and cultural realities of Middle Tennesseans.

3. While the state believes that the proposed coordinated approach will improve continuity of care broadly, TennCare is particularly concerned with maintaining the highest quality of care for those individuals on our program with SED and SPMI.

a. Please describe your experience with these populations, including specific programs and interventions (e.g. early intervention, psychiatric rehabilitation and recovery).

As a Tennessee based company, Advantage, through its ownership relationship with Centerstone Community Mental Health Centers, Inc. and strong network affiliations with other providers of behavioral health services, has more comprehensive, results-oriented experience in treating individuals with SPMI and SED than any other managed behavioral health network in Middle Tennessee. Through the efforts of over 800 clinicians and treatment staff, 61 facilities and over 150 locations, Centerstone alone

treated approximately 24,000 priority population TennCare enrollees (including 7000 SED children and youth) during the twelve month period ending June 30, 2005. In total, for the 2005 fiscal year, Centerstone treated 47,000 unduplicated individuals seeking care for their behavioral health disorders and concerns.

A full array of behavioral health services is available for integration with the medical community. Building on the strength of key providers, WHP-Advantage's core network of services and programs encompasses state of the art treatments and interventions using both innovative and proven therapies to meet the behavioral health needs of individuals and families. Grounded in the principles of recovery and resilience, these behavioral health programs and interventions span a full continuum beginning with prevention and early intervention extending to residential and inpatient 24-hour services.

b. What structural or contractual design choices would you recommend to ensure the needs of these populations are met?

Design Recommendations -

1. The contractual design for behavioral health services should reflect the State's program objectives for improving the behavioral health delivery system in the 21st century. While the WHP-Advantage partnership understands and supports the need for strong regulatory requirements, the ultimate redesign should carefully analyze current evaluation measures that focus on process and eliminate requirements that do not clinically demonstrate improved clinical outcomes.

2. The modern design should measure and reward the use of technology to improve coordination of care and reduce costs, implementation of evidence-based practices, desired clinical outcomes, and effective use of traditional and alternative treatments. Rewarding these types of initiatives will advance transformation of the behavioral health delivery system and improve treatment outcomes for TennCare enrollees.

3. The structural design should recognize the contribution of all providers from across the behavioral and medical continuum in the delivery of effective mental health and substance abuse treatments for SPMI and SED enrollees. The reformed model of TennCare managed care should address the credentialing and contracting of behavioral health services rendered by primary care providers, endorse reimbursement of effective alternative behavioral health supports (such as peer supports, expanded telemedicine treatments, and telephone interventions) and reward performance incentives for enrollee, family and population-specific interventions that achieve outcome goals and address systemic delivery system problems (such as EPSDT screenings and pharmacy management).

4. In light of the significant investment to be made in the care delivery system related to technology, training, and data collection, a contract term of 4-5 years should be considered. Additionally, the structural and contractual design should be based on reliable encounter data and financial information. Funding of the behavioral health design for the SPMI and SED enrollees should be actuarially and fiscally sound.

5. Accurate and timely pharmacy data is required to fully manage and reform the delivery system and enrollee outcomes.

6. An alternative program design to be considered is the use of a Population-based Disease Management (PDM) overlay on top of the MCO benefits to safeguard access and quality of care for special behavioral health (i.e. SPMI and SED) populations. This PDM overlay would facilitate coordination of medical and behavioral healthcare, provide specialized consumer education, facilitation of access where needed, health advocacy and coordination of services between other state agencies and the MCOs. Like a specialized customer service function, the PDM program would supplement, not supplant, the benefits and services provided by the integrated managed care entity. It could be an important step to ensure that the needs of individuals with SPMI and SED are met.

c. Would your interest level in bidding be positively or negatively impacted if the state were to consider excluding these individuals from this proposal?

Our interest in bidding remains positive with the inclusion of the SPMI and SED enrollees. These individuals tend to have some of the most complex and unique healthcare needs; thus, these individuals present as a primary "driver" in the pursuit of an integrated, innovative and outcome driven delivery system. Less will likely be accomplished in the managed care integration endeavor if the medical and behavioral health delivery systems continue to treat individuals with SPMI and SED conditions without consideration to "patient-centered"care coordination.

Please give consideration to the following:

1. To protect the treatment interests of SPMI and SED enrollees, the regulatory oversight agency should have behavioral health expertise and experience, with current knowledge of the behavioral health delivery system so as to promote up-to-date, evidence-based best practices and reinforce "consumer-centered" clinical practice.

2. The State's TennCare reform objectives related to integrated physical and behavioral health services and behavioral health disease management would be greatly diminished, if the SPMI and SED populations are carved out to a separate entity. The WHP-Advantage partnership would prefer to retain the SPMI and SED enrollees in the proposed carve-in for the application of an integrated disease management approach.

3. Maintaining a TennCare behavioral health carve-out for SPMI and SED enrollees while adding an integrated carve-in entity serves to increase program complexity, administrative hassle, redundancy and costs for enrollees, providers, managed care entities and the State. It is contrary to the State's desire to establish a consolidated delivery system.

d. Would your response to (c) change if the state were to adopt an alternative, more limited or no-risk arrangement for this population?

TennCare enrollees with SPMI and SED need coordination of care across the medical and behavioral health delivery systems. The introduction of a more limited or no risk arrangement would be beneficial, at least during a reasonable transition period.

Transition to a carve-in managed care model will take a period of time to implement successfully. During the start-up and transition period of at least 1 year, implementing risk protection to the MCO would, in our view, make sense.

4. **Please describe your experience working with essential community providers such as community health clinics and community mental health agencies.**

Advantage is a wholly owned company of the largest community mental health agency (CMHAs) in the State of Tennessee. Additionally, Advantage's leadership has extensive experience in working with community mental health agencies throughout the State of Tennessee. Experience in working with the community mental health agencies and their trade organization, TAMHO (Tennessee Association of Mental Health Organizations), encompasses a host of endeavors over a number of years. The respect and trust that exists today between the Advantage leadership team and the CMHAs will help ensure the development and execution of a plan to transform the current carve out behavioral health network to a fully coordinated physical and behavioral health delivery system

5. **Based on your experience coordinating physical and behavioral health services, do you have any specific recommendations regarding the design of the behavioral health proposal for TennCare? More specifically, what financial guarantees, if any, might be necessary to ensure appropriate funding for these critical services?**

Behavioral Health Proposal Recommendations:

1. Make available a library of reference documents relevant for the behavioral health RFP response, pricing proposal and behavioral health specific Proforma Contract language, via Internet web site and/or hard copy access. For example: all current BHO contracts and amendments, Consent Decrees, TN Mental Health Law, BHO quarterly and annual financial filings (including the BHO Medical Loss Ratio Reports), and EQRO and State of TN departmental BHO oversight audit reports.

2. Make available State readiness review checklist(s) for behavioral health services so that bidders may consider the start-up/implementation staffing and financial resources needed for a fully informed decision to bid. Information to successful bidders during the transition period minimally should include: member benefit accumulators, current care authorizations, out-of-area care, etc.

3. Provide scoring credit for proposals that include applications of the recovery model for adults and resilience principles for children and families.

4. Incorporate scoring awards that stimulate change to the coordinated physical and behavioral health delivery system consistent with the State's policy objectives. Specifically, allocate scoring points for the use of technology, evidence-based practices and other innovations (such as recovery and resiliency) that yield measurable performance and outcomes for all stakeholders. Also, allocate points for technology solutions that support increased efficiency, accuracy and a reduction in hard copy paperwork.

5. Award points for bidders that commit to reinvestment of a percentage of medical savings in the Tennessee delivery system for improvements prior to retention of savings as surplus.

6. Provide a certified data book that presents three years of historical encounter and financial information for all behavioral health medical loss costs including services performed by physical health providers.

7. Present historical financial data in a format that is directly compatible with the Financial Assumptions section of the bid. All data should be specific to the Middle Grand Region and population categories as represented by the RFP capitation rate cells.

8. Identify the historical payment methodologies for different types of required services; identify and provide financial data for services/programs that use a grant payment methodology.

9. Identify and provide claims paid historical data for all classes of enrollees specially treated under the BHO Proforma Contract (e.g. Judicials, State Onlys, Mandatory Outpatient Treatment)

10. In light of the significant investment to be made in the care delivery system related to coordination of care, technology, training, capacity improvements and data collection, a contract term of 4-5 years should be considered. Start-up dollars should be made available to address service gaps and capacity development in the behavioral health delivery system.

11. An alternative limited risk or non-risk financing arrangement should be considered for the SPMI and SED enrollees during a "no harm period" to allow for transition, capacity development and data/information collection. SPMI and SED enrollees involved in the behavioral health disease management program should receive special funding consideration.

12. For children in State custody, clearly specify the services for which the BHO is responsible and under which circumstances (e.g. residential treatment). Provide BHO claims payment history to date for this group.

13. Consider a financial incentive or positive cost adjustment for the managed care entity that performs optimally; thus, attracting enrollees with a disproportionate share of medical risk. Optimal performance including alignment with the "sought after" network providers will naturally be attractive to SPMI and SED enrollees.

B. Pharmacy

1. Please describe your approach to a pharmacy carve-out, including specific information on your approach to pharmacy management and cost containment strategies.

WHP's staff has developed a working relationship with the current TennCare[sm] PBM and communicates with key personnel on an ongoing and as needed basis regarding TennCare[sm] member pharmacy issues. This established relationship would be

strengthened with Advantage resources and expertise and the formalization of pharmacy management and cost containment strategies across all health and disease categories. Examples of activities that exemplify our approach follow:

- Expansion of monitoring of prescribing patterns of providers to include profiling generic use patterns and intervening with providers regarding substitution where therapeutic equivalents are available
- Profiling provider related patterns by medication class per patient panels to determine if utilization rates are appropriate for their specialty and case mix of patients
- Coordination with disease management so that patients with chronic diseases are prescribed medication shown by evidenced based guidelines to improve quality of life or impact utilization (i.e. ACE inhibitors in CHF, inhaled steroids in asthma, behavioral healthcare algorithms).
- Capitalize on provider efforts to manage pharmacy and retain high enrollee satisfaction and clinical outcome.

In order to accomplish these tasks, information from the PBM must be available in an easy to access format and be timely.

2. In a pharmacy carve-out scenario, what "real-time" information would you need to manage the benefit? Please be specific.

Effective management of pharmacy benefits requires information availability at the time of the clinical decision. Optimally, the best environment is "real time" information from all applicable parties including the PBM and all prescribers at all times. Access to real time information requires the use of a comprehensive and effective technology solution that connects all the pharmacy stakeholders. WHP-Advantage contemplates the use of such a system that calls for PBM, managed care and major provider delivery system connectivity. Beyond information contained within its own systems, it is essential to know when enrollees receive their medications and whether any deviations occur, e.g. prescription was only partially filled. This information should be available via patient pharmacy profiles from the PBM that are easily accessible. This information may be obtained via a secure Internet application with date of prescription fills, quantity and days supplied.

Reliable management reports from the PBM, on a frequent and regular basis, are essential to a company's ability to effectively manage prescribers and positively impact pharmaceutical utilization. Reports are needed regarding individual prescribers and enrollees, as well as aggregate roll up reports and trend reports. The remainder of reports needed to access patient's health and medication status could be generated from pharmacy claims data if the data received from the PBM were current and clean.

C. Long-Term Care Services

1. Please describe your methods and procedures for coordinating acute and long-term care services to reduce gaps in services and prevent duplication of services.

WHP has a well defined and implemented Utilization Management (UM) program and UM staff that utilize InterQual and specific criteria for the coordination of acute and long-term care services. Coordination at the UM level for transfer from acute hospital to long term care with appropriate application of acute rehab, SNF rehab and home health criteria is utilized to ensure that patients receive needed services at the most cost effective levels of service. Also, monitoring of patients in custodial level of care by case managers is used to improve MD follow-up and coordination with facility case management and pharmacy management.

While WHP has worked hard to coordinate acute and long term care services, the perception remains that these patients and those in home and community based waiver programs have often been underserved or not served at all. Much of what is known or presumed about these individuals and their needs has not been systematically verified. Before efforts are made to better address their needs, some time and effort should be spent assessing the circumstances, needs and the kinds of services that would best benefit these enrollees. While they could derive some benefit from some existing services, it is likely that specific services and programs would need to be developed.

WHP-Advantage recognizes there are significant unmet needs among the elderly and those with developmental disabilities and mental retardation. If awarded a contract, WHP-Advantage is prepared to invest the resources necessary to conduct a study, as described in the previous paragraph, and submit to the State a proposal regarding appropriate services and programs.

2. What incentives would you recommend including in the MCO contract to drive home and community-based services as a viable alternative to institutional care?

a. A managed care entity performance incentive should be considered for the identification, early intervention and effective utilization of home and community-based services for enrollees with medical conditions, mental illness, substance abuse disorders and co-occurring developmental disabilities.

b. Increased funding levels for contracted Home Health Agencies are necessary to deliver an enhanced level of home services in the current environment of nursing provider scarcity.

c. An additional management fee for participating PCPs who have large numbers of TennCare[sm] patients and specific agency providers so services can be deployed in a more timely manner.

d. An enhanced payment for specialized treatment providers with expertise in treating complex populations. An example would be evidence based in-home treatment for youth and teens with co-occurring mental health and developmental disabilities.

e. Reimburse alternative community based services which provide for the mental health and substance abuse needs of the home and community-based services enrollees. Examples include: play therapy, Prevention and Management of Aggressive Behavior paraprofessional training, infant stimulation, school-based interventions, and psychosocial/activities of daily living.

f. Start-up funding should be available for the development of specialized behavioral health interventions and services for these highly complex and hard to treat enrollee cases.

D. EPSDT Incentives

1. Please describe your current approach to EPSDT services, including your outreach and education component. In addition, if you currently use physician incentive programs to increase participation in EPSDT, please describe these initiatives. Also, please provide us with your recommendations regarding the proposed incentives for MCOs, including appropriate and measurable targets, and meaningful incentives.

As partners in the delivery of high quality coordinated care, the WHP-Advantage team will strive to improve EPSDT screening rates and compliance with periodicity schedules through the ongoing education of both enrollees seeking medical and behavioral health services and members of its provider network. It is essential that those who can benefit from these services be aware of their availability and value and that those providing any aspect of the services promote their benefits and encourage their use.

WHP's TENNderCARE Program is a comprehensive program of checkups and health care services for WHP TennCare Medicaid members under age 21. EPSDT services are provided under the TENNderCARE Program. Educational materials developed include the availability of specific EPSDT services and benefits as defined in the Contractor Risk Agreement. EPSDT services available to members also include case management when appropriate.

WHP provides non-emergent transportation services to members who require this service. All educational materials provided to members include information on how the member may obtain transportation services including availability of scheduling assistance if needed.

Educational materials were developed utilizing various tools to identify the social, cultural and economic indicators to assist in identifying the needs of our members. Written material is provided in Spanish as required per the Contractor Risk Agreement. In cases of verbal communication, WHP identifies language barriers of our members and utilizes the interpreting services of the AT&T Language Line. WHP also identifies the primary and secondary languages of our providers to further assist in providing care to the plan's members who are deficient in the English language. WHP has member information available in alternative formats that include Braille for members with impaired vision and TDD telephone service for the hearing impaired. A recording is maintained with TENNderCare information for use with the limited-reading population. WHP provides written materials in a 6^{th} grade level or lower, when possible. For members identified with a low literacy level, a list of agencies is maintained to use for referral if needed.

WHP's established EPSDT program includes outreach to members through various "touches" as defined in the TennCare Contractor Risk Agreement. Informing efforts for members include, but are not limited to:

- *Member Handbook:*

New member packets are mailed by the Eligibility Department within 30 days of receipt of notification of enrollment. The packet includes the WHP TennCare Handbook and Explanation of Coverage. The member handbook includes information about the TENNderCare program and how to access services. On an annual basis an updated member handbook is mailed to members.

- *Member and Provider Quarterly Newsletters:*

WHP publishes a member and a provider newsletter quarterly that contains at least one article pertaining to the TENNderCARE Program and EPSDT services available to encourage members to obtain screenings and other preventive care services. The newsletters are also utilized to inform members and providers of updates about services and benefits.

- *EPSDT Reminders:*

  - An EPSDT database report is generated on a monthly basis to identify members according to birth month/age. These members are mailed a reminder notice for age appropriate screenings that are due. The reminders include an offer of transportation and scheduling assistance.

  - "Birthday" reminders are mailed annually to all members at least six weeks prior to the member's birth month.

  - Members under 2 years of age are identified and mailed preventive well visit reminders based on the periodicity schedule.

  - A report is also generated to identify "new members" who have been in the plan for approximately 60 days. A follow up letter is sent to these members explaining the TENNderCARE Program and intervals for health visits and immunizations. This information supports the material received by the member in the "member packet".

  - "Did You Forget?" reminders are sent to members who are not up to date with their screenings. This list is reviewed to identify members who have not had an EPSDT visit and who, in the past three months, received a reminder postcard (birthday or preventive).

  - A list of members who still remain on the monthly report as not having utilized services for six months is sent to the member's assigned Primary Care Physician (PCP).

- *Dental Services*

  TennCare Medicaid members are informed that dental care is available under the TENNderCARE Program and that no referral is required from their Primary Care Provider. Members are provided the phone number of the Dental Benefits Manager.

- *Provider Specific Education*
  A Provider "TENNderCARE Guide" was developed and distributed to Providers during onsite visits. This guide is updated at least annually and contains educational materials related to required components of EPSDT services, coding information, sample documentation forms, etc.

WHP has developed a monitoring tool that mirrors the CMS 416 reporting criteria. This report is generated on a monthly basis in order to assist with monitoring of compliance rates for this population. Data is utilized to evaluate efforts to improve access and coordination. WHP plans to continue to work closely with our provider base to develop meaningful reports that will distribute findings of the data analysis and provide recommendations for improvement to PCPs and behavioral health providers

Managed care performance incentives should be considered for the following:

a. Creation of identification and referral methods across physical and behavioral health providers that improve EPSDT rates

b. Implementation of enrollee and/or consumer sponsored campaigns that improve EPSDT rates and population risk factors

c. Utilization of technology solutions to more timely coordinate and expedite services for children entering State custody and for children and families considered "at risk" of custody.

E. Utilization Management/Medical Management (UM/MM)

1. Please describe any experience you have managing care in a state with benefit limits, including both "hard" and "soft" limits. In particular, please describe any experience you have had implementing prior authorization processes as a mechanism to authorize services in excess of benefit limits. Please describe the prior authorization process you would employ for "soft" limits and the general criteria that would be utilized to evaluate requests.

Both the WHP and Advantage leadership teams have applicable experience in the management of benefit plans and benefit limits. Health benefit design nationally, especially in commercial and private Medicare insurance plans, is characterized by hard limits in the form of types of services, numbers of services and maximum allowable dollars. WHP-Advantage utilization management staff and providers have experience with the challenge of creatively stretching hard benefit limits and/or negotiating soft limits to address very serious healthcare concerns.

WHP has established a Utilization Management program that is designed to effectuate the stewardship role of the health plan in administering covered benefits performed by Network Providers to individual members and the aggregate membership in accordance with medical appropriateness. The Utilization Management Program is a comprehensive, systematic, and ongoing integrated health plan function. It incorporates prospective, concurrent, and retrospective utilization review as well as case management to meet program objectives. The medical service areas reviewed include emergency care, inpatient hospitalization, outpatient surgery, selected outpatient services, rehabilitative

services, home care, selected pharmaceutical services, selected ancillary services, and physician office services. The Utilization Nurses and Case Managers monitor the program's continuity and coordination of care. Utilization patterns are tracked to identify potential over-utilization and under-utilization of medical services. The goal of the plan is to facilitate and support high quality, medically appropriate care efficiently within a budget for covered benefits that is financially supported by premium revenues and to evaluate, monitor and coordinate services for members of the Health Plan.

Continuing objectives of the program include:

- To provide access to high quality health care services in the most appropriate and cost efficient setting.
- To facilitate communication and develop partnerships among members, providers, and the health plan in an effort to enhance cooperation and appropriate utilization of health services.
- To monitor and evaluate utilization patterns of contracted physicians and provide feedback to physicians about these patterns.
- To identify and provide utilization and case management services for members considered at high risk for incurring significant health expenses, or requiring extensive and ongoing medical care for chronic or catastrophic illness.
- To assist in controlling overall healthcare expenditures by developing and implementing programs which encourage utilization of preventive services and self-management of chronic conditions.
- To improve the quality and cost effectiveness of care provided to members with targeted clinical conditions through condition management programs.
- To identify clinical practice guidelines to be promoted for use by health plan providers.
- To assist the Chief Medical Officer and the internal peer review committee in reviewing medical utilization of individual cases**.**
- To support the WHP Corporate Compliance Plan's goal of improving the clinical and non-clinical quality of care and service and the organization's commitment to provide health services in compliance with all applicable laws, regulations and standards.

The WHP-Advantage team is motivated to minimize the exhaustion of hard limits as proposed for the reformed TennCare program. With respect to the use of "soft limits", the WHP-Advantage team would prefer to set "hard" benefit expectations and avoid the confusion and emotional distress that can accompany the negotiation for services beyond the applicable limits. Additionally, WHP-Advantage, in the application of utilization management and quality protocols, prefers to be consistent and reliable as deviations potentially impact accreditation and quality reviews and carry potential legal implications.

2. Based on your experience, please provide any recommendations regarding specific UM/MM requirements for the State to consider, particularly the use of "soft" limits.

a. A data collection period should be established for determination of potential benefit quantity and associated financial risk for soft benefit utilization for both medical and behavioral health services. An alternative non-risk arrangement should be considered during the data collection period. For example, required hard benefit exceptions should be administered by the

managed care entity based on State guidelines including State fiscal responsibility.

b. A performance incentive should be considered for the identification, early intervention and effective treatment of co-occurring disorders. For certain chronic or co-occurring illnesses, consider a short list of benefits that would not count against the hard limit. For example, a transplant patient with co-occurring mental illness.
c. Development and start-up dollars should be made available for the expansion of the delivery system to include alternative inpatient and residential programs/services (e.g. 24 hour observation, behavioral health crisis stabilization with a medical component)
d. Alternative community based services should be established for community based Nurse Practitioners to be available for chronic patient service and outreach.
e. Alternative community based services established for the treatment of substance abuse and co-occurring disorders should be considered reimbursable under an effective UM program.

F. Disease Management

Medical

1. **Do you have a formal disease management program? If yes, where is it currently being used, e.g., which State Medicaid programs? Again, if yes, on which conditions does your program focus today?**

WHP has established two disease management programs for our TennCare enrollees involving diabetes and asthma. The disease management programs are implemented as systems to coordinate healthcare communications and interventions for populations with these conditions in which patient self-care efforts are significant. Disease Management supports the practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based guidelines and patient empowerment strategies and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

2. **Is the function fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.**

The function of WHP's Disease Management programs is fully performed within WHP and the components of the programs are conducted by RN's with knowledge of the Disease Management process.

3. **Please describe your disease management approach and address each of the above conditions specifically. Include in your description how you identify individuals in need of disease management intervention more broadly (including potential future high-cost utilizers); your outreach and education approach; the number of individuals served; your approach to physician behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing with the context of benefit limits; and a description of measurable outcomes resulting from the disease management intervention. Please also**

describe what additional health conditions you might recommend for targeted intervention techniques (e.g. obesity, pain management)?

Medical

I. The Asthma Case/Disease Management Program emphasizes the importance of education and self-management techniques for members with asthma. The Health Services staff follows defined processes to achieve the purpose of the program which is to cost-effectively utilize, coordinate, evaluate, monitor, track and trend asthma services, identify and educate members with asthma on how to achieve a better quality of life with few limitations and be compliant with medication regimen, have less dependency on others (including the medical system) and live with a disease that cannot be cured but can be effectively managed, and to provide program outcomes. An effective approach to the fulfillment of this purpose includes: environmental control, pharmacologic management, immunotherapy and vaccination.

II. The Diabetes Case/Disease Management Program was established by utilization of the nationally accepted, evidence-based practice guidelines of the American Association of Clinical Endocrinologists (AACE), and information from the American Diabetes Association (ADA). Other components of the program are derived from the educational materials that are developed internally and approved by all the appropriate committees within WHP. Reference materials/information from nationally recognized associations/corporations or pharmaceutical companies that work closely with diabetic patients or diabetic medications/supplies may be used internally by the Disease/Case Manager for explanation of the disease, medications, supplies, DME, etc. (e.g., HAYES, drug manufacturer's insert information, PDR, reputable websites, etc.). The program applies to internal and external functions, including health plan services and internal performances, as well as clinical processes and outcomes of care provided by contracted health providers and the compliance of the members included in the program. The program is available to all plan members with diabetes and is especially encouraged for high-risk diabetics.

    The purpose of the program is to cost-effectively utilize, coordinate, evaluate, monitor, track and trend diabetic medical services, identify and educate members with diabetes on how to achieve a better quality of life with few limitations, emphasize the importance of medication compliance and use of diabetic supplies to monitor the disease, reduce dependency on others (including the medical system) and live with a disease that cannot be cured but can be effectively managed based on the above definitions for CM and DM processes and to provide outcomes of the program.

The components of the disease management program include:

- "Population identification" processes
- Evidence-based practice guidelines
- Collaborative practice models to include physician and support-service providers
- Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance)

- Process and outcomes measurement, evaluation and management
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling)

Behavioral Health

As noted in our response to Question 3B concerning design recommendations, the WHP-Advantage team recommends that consideration be given to providing a Population-based Disease Management overlay to enhance consumer education and facilitate access for enrollees with serious mental illness and serious emotional disturbance. This type of innovation in health system design can ensure a recovery oriented approach to care, provide health advocates for enrollees with these chronic conditions and help to ensure access to care. It would supplement, not supplant, the important efforts of providing care coordination, treatment and supports to enrollees.

4. Does your care management program include behavioral health conditions? If yes, where is it currently being used?

The WHP-Advantage team supports and has extensive experience in disease and care management approaches for the treatment and support of medical and behavioral health conditions. Our recovery based treatment philosophy and strong support of consumer centered care provide a platform for the implementation of cost effective care management approaches that are formally recognized as disease management interventions. Advantage is developing a provider network experienced in delivering care for individuals with serious mental illness and substance abuse concerns. The Advantage network will be adequate to cover the entire Grand Middle Region. Advantage plans to use a comprehensive approach to care management that incorporates the principles and practices of disease management, in addition to face to face case management activities. Specifically, WHP-Advantage will have the ability to identify, through its data systems, individuals who are most in need of services or at risk of needing more intensive services.

5. Is the function for behavioral health care management fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

WHP intends to subcontract with Advantage for the provision of behavioral health disease management services. As integrated physical and behavioral managed care partners, management technology, data collection and shared business processes across the continuum of medical and behavioral services will be critical to the optimal performance of the disease management program. Through review of information and data from all sources including medical, behavioral, PBM, and the provider EMR, the proactive engagement of the enrollee, family and key provider(s) will be actualized.

6. Please describe your care management approach to behavioral health conditions, addressing each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions; your outreach and education approach; approach to co-morbid mental and physical

conditions; the number of individuals served; your approach to provider behavior, including the use of clinical guidelines, staff qualifications; your experience and approach to managing within benefit limits; and a description of measurable outcomes resulting from the management intervention.

Through its partnership with Advantage, WHP is prepared to provide an integrated and state-of-the-art program of care management for behavioral health and medical conditions. The plan will include the major elements in disease management as outlined by the Disease Management Association of America. These will be supplemented with a variety of peer support and recovery based services. All of these components will include a comprehensive and integrated quality improvement system.

Through a shared claims and data warehouse system, Advantage will proactively identify consumers receiving treatment for depression, schizophrenia, bipolar disorders and co-occurring conditions. Research has clearly identified that individuals with serious mental illness have a greater need for coordinated medical services than the general population. Advantage and WHP will use established protocols for tracking and coordinating the behavioral and medical care for these individuals. These protocols will identify those individuals with behavioral health illnesses who are at high risk for adverse health conditions including and also resulting from obesity, diabetes, smoking, and medication related side effects. WHP care management staff will be notified and treatment protocols developed for these individuals. Treatment protocols and shared information between WHP and Advantage will aid network providers in the coordination of the physical and behavioral health care needs of enrollees.

Clinical guidelines and evidence based practices guide the training and clinical development of the network and its vision for improvement. Advantage's relationship with Centerstone affords network providers the opportunity to participate in the latest in clinical guideline trainings for the treatment of serious mental illness and co-occurring conditions. Ongoing efforts in this area that are shared with the Advantage network will serve to advance evidence-based care within the WHP-Advantage health care network.

WHP-Advantage strongly believes that disease management approaches and the integration of behavioral and physical health services will reduce costs and improve outcomes over the life of a TennCare contract. Cost offsets in physical health, long term improvements in employment rates and independence, improved self-confidence and satisfaction with care are among the ultimate measures of outcome in behavioral health. treatment. The partnership believes that it can achieve these outcomes within the benefit limits described for the program as long as the contract allows for needed flexibility, innovations and a formulary for psycho-pharmaceutical benefits which include a sufficient number of drugs appropriate for each condition and methods to ensure that individuals can gain access to other drugs when needed.

G. Capitation Model

1. **Please describe your experience operating under a risk contract for Medicaid and any concerns or recommendations associated with this approach.**

WHP operated successfully under capitated risk from the inception of TennCare through June 30, 2002 when the Bureau initiated the "stabilization" program and began underwriting the medical risk itself. Further, senior management of WHP has successfully operated Medicaid risk plans in Pennsylvania, Florida and Missouri. Based upon WHP's experience with TennCare and experience in other states, we respectfully recommend that the Bureau address the following issues in the new contracting model for TennCare.

Recommendations associated with a risk contract for TennCare follow:

a. **MCO Accountability.** Everyone will agree that contracted MCO's should be held accountable for their performance under the contract. We believe the accountability process should be driven by agreed-upon performance metrics that are oriented toward outcomes as opposed to process. We believe the current Contractor Risk Agreement has become overly prescriptive as to process. While the WHP-Advantage partnership understands and supports the need for strong regulatory requirements, the ultimate redesign should carefully analyze current evaluation measures that focus on process and requirements not clinically demonstrated to improve clinical outcomes. As the TennCare contract returns to a risk arrangement, certain accountabilities and processes will need to be the responsibility of the MCOs especially in the areas of provider contracting and medical management where constant innovation is needed to manage within a fixed payment structure.

b. **Adverse Selection.** The breadth of eligibility categories existing in TennCare creates risks associated with adverse selection that are higher than many other state's Medicaid programs which have narrower eligibility. In simple terms, adverse selection may be seen in generally higher utilization of services (frequency risk), or the occurrence of catastrophic cases (intensity risk). Recognizing these risks and building safeguards into the contracting process such as population severity indexing, individualized risk factors (such as the CMS model), and pooling of catastrophic risk would help assure the financial stability of contracting MCO's. Such safeguards would not increase overall program costs to the State but would assure that relative capitations paid to MCO's would recognize that risks are rarely, if ever, evenly distributed among MCO's. An example would be the risk adjustment reimbursement established by Medicare as a means of risk adjustment based on severity of illness represented within the MCO's enrollee population. Another suggestion for addressing adverse selection would be a financial incentive or positive cost adjustment for the managed care entity that performs optimally; thus, purposefully attracting enrollees with a disproportionate share of medical risk. Optimal performance including alignment with the "sought after" network providers will naturally be attractive to enrollees with multiple chronic conditions and severe illness including the SPMI and SED population.

c. **Retroactive Eligibility Determinations.** The Bureau must recognize the adverse financial impacts of retroactive eligibility determinations in categories of enrollees where medical and/or behavioral health needs are the

driver of eligibility. Not only do large retroactive medical claims accompany the placement of these enrollees with the MCO, but subsequent utilization is also typically high. This problem could be mitigated by the pooling of retroactive risks or the reimbursement of retroactive claims by the Bureau. Another method of dealing with this issue is similar to what has been done in other states, which is to institute maternity or other case rates paid to the MCO for members who became eligible based upon presentation for certain types of medical conditions. This type methodology could be utilized for most medical and behavioral health eligibles.

d. **Benchmark Fee Schedule.** Based upon our experience in the Middle Tennessee market in the commercial, Medicare, and TennCare lines of business, we believe the variability in fee-for-service rates paid to providers of services in this region is, by far, the highest in TennCare. There are a number of historical reasons for these disparities which have, unfortunately, left a legacy of both under-reimbursement and over-reimbursement that will need to be overcome by MCO's in the new environment. WHP believes the Bureau can and should establish a benchmark fee schedule which MCO's would be authorized to pay non-participating providers for out-of-network services. The establishment of a benchmark would begin to foster a rational contracting environment for TennCare services. For the commercial and private Medicare marketplace, the federal Medicare rates are generally used as a reference point in setting benchmarks. We believe TennCare could adopt a fixed percentage of the Medicare rates as the reference point in setting TennCare benchmark rates both for medical and hospital services. The benchmark must be at such a level as to allow the MCO's the opportunity to reimburse in-network providers at better rates than out-of-network providers.

e. **Actuarial Study.** In the new risk model, the State may choose to set capitation rates as was previously done or may elect to solicit bids for rates and/or benefits from MCO's. In either case, the Bureau will undoubtedly seek an actuarial study to support either the rate setting or bid evaluation process, as required by federal regulations. In the past, actuarial studies performed on behalf of TennCare have gone to great lengths to analyze medical service utilization but failed to analyze real market pricing for services. Future actuarial studies need to analyze both utilization and cost of medical and behavioral services to adequately reflect market conditions to which MCO's are subjected. Establishment of benchmark rates as described in item "d." above would articulate with the actuarial process in establishing a financial framework within which the managed care entity could evaluate and manage risk.

f. **Contract Termination.** The Contractor Risk Agreement between TennCare and each MCO has historically been cancelable by TennCare without cause upon 30 days notice. While we acknowledge that we are not aware of any cases where this provision was used to terminate an MCO's contract, it has the practical effect of reducing the Bureau's commitment to the contract to a rolling 30 days. In our view, this provision has the potential

to undermine the relationship between the Bureau and the MCO and should not be a part of the new contract.

If the Bureau believes they need, or are required, to have such a "convenience" clause, the MCO should be compensated for costs associated with the wind-up of its TennCare business including commitments made by the MCO in reliance upon the stated contract period.

g. **Risk Share.** The WHP-Advantage partnership believes that ultimately moving to a full risk contract is in the best interest of the MCO and the State in the long term. We also believe that, initially, a shared risk arrangement that over time graduates toward full risk would be desirable. This type of phase-in model has been utilized successfully in other states. We would support the introduction of a shared risk model whereby the MCO's have an established risk corridor around an actuarially sound benchmark. Within this corridor of risk, the MCO and the State would share risk equally. Above and below this corridor, the State would retain the risk. We further believe that this type approach coupled with addressing the issues discussed in this Section G will provide a very meaningful risk relationship between the State and the MCO and set the stage for ultimately returning to a full-risk model. We believe this may be needed to allow time for all the programmatic changes to be assimilated and reflected in the medical cost and trend data. We believe that to reach actuarially sound capitation rates, information that relates to items such as how the effects of retroactive eligibility will be mitigated, the level of costs that will be associated with the proposed "soft benefit limits", the method used to address maternity case rates associated with late-term enrollees, how the State handles the reinsurance pool and catastrophic claims, the effect of a benchmark fee schedule, how the State proposes to address the urban versus rural disparities in provider capacity, adjustment of rates as to adverse selection, and the impact of changes in eligibility needs to be reflected in the medical utilization and cost data. We believe that until the above items are reflected in the actuarial studies, it will be very difficult to set sound actuarial rates.

2. Please indicate if a full-risk capitation environment would negatively or positively affect your decision to participate.

Assuming the Bureau addresses the recommendations listed, we believe that moving MCO's through the risk sharing phase-in and ultimately, over time, to a full-risk capitated environment would positively affect our decision to participate.

3. The State is committed to a capitated approach for the core benefit package, as described above, for all enrollees. If you prefer an arrangement other than full risk, however, please describe the mechanisms you would prefer, such as:

a. State supported stop loss provisions based on annual per member expenditures (e.g., the state reimburses X% of costs between $X and $X per member per year)

b. If the State adopted "soft" benefit limits, State supported stop loss provisions based on per member benefit utilization (e.g., the state reimburses X% of hospital visits over the 20 day annual limit

c. If the State adopted "soft" benefit limits, aggregate risk sharing (e.g., the state reimburses X% of costs in excess of X% of capitation payments)

d. Other

Please see the responses above in Section G. Also, addressed above under Section E, the WHP-Advantage partnership does not support the administration of "soft" benefit limits as the sole responsibility of the managed care entity.

4. Does your participation depend upon a minimum number of covered lives? If yes, what is the minimum number?

In order to have adequate impact in the market for medical, hospital and behavioral health services, and to enable economies of scale in administration, WHP recommends a minimum enrollment of 150,000.

H. Data and Systems Capability

1. Please list and describe data, including encounter data, and reports you have experience producing for external monitoring. Please list those states for whom you provide this information.

WHP provides both routine and ad hoc reports to the TennCare Bureau as required under the Contractor Risk Agreement. Attachment III lists various reports produced for TennCare. Attachment IV lists reports produced for Medicare.

2. Please describe how and what data you use to monitor, measure, and evaluate your performance, including the performance of your network providers and any subcontractors. Please be as specific as possible.

WHP utilizes a data warehouse and sophisticated data mining tools to routinely monitor the plan's operating performance. The warehouse, which is updated daily, contains all membership, provider and claims data and is able to produce virtually any report requested. WHP also regularly produces reports from its automated telephone system and from its customer contact database, CCONT.

Efficiencies will be gained through Advantage's sharing of the WHP data warehouse. Together, WHP and Advantage will utilize the shared medical and behavioral health data for management of enrollee benefits, quality improvement activities, and enrollee and provider utilization management.

I. Net Worth and Restricted Deposit Requirements

1. Do you consider the net worth and depositing requirements to be a deterrent to contracting with TennCare? If so, please explain.

WHP does not view the net worth and depositing requirements to be a problem.

J. Implementation Timeframe

1. Does the anticipated timeframe of an April 2006 contract award and an October 2006 implementation date impact your decision whether to participate in the program? If yes, how?

As a current participant in the TennCare program, WHP-Advantage is prepared to meet the timetable outlined in the RFI.

2. Do you have suggestions or recommendations regarding the procurement and implementation timeframe? What is your recommended minimal and optimal timeframe between contract award and implementation?

WHP-Advantage believes the timeframe outlined in the RFI is achievable.

Windsor Health Group
and
Windsor Health Plan Management Team

Philip Hertik is Chairman and CEO of Windsor Health Group, Inc. which was founded in 2000 to serve as a holding company for health care related acquisitions. Windsor currently owns and operates Windsor Health Plan of TN, a managed healthcare plan serving TennCare and Medicare Advantage enrollees; Windsor HomeCare Network, a specialty managed care company which organizes and manages networks of home healthcare providers; and 50 Plus Strategies, a financial services firm targeting the senior population.

Prior to founding Windsor, Mr. Hertik served as an independent consultant and investor in health care companies, including the founding of a dental practice management company on behalf of CompDent Corporation and a national private equity firm, serving as the company's first president.

Mr. Hertik was formerly the chairman and chief executive officer of Coventry Corporation (now Coventry Health Care), a publicly traded regional managed care and insurance organization. During Mr. Hertik's eight-year tenure with Coventry, the company grew through acquisitions and significant internal growth from $50 million in revenues to nearly $1 billion, with the market value of the company's equity exceeding $700 million. Coventry continues as a successful public company today with an equity value in excess of $5 billion.

Prior to joining Coventry, Mr. Hertik served in senior executive capacities for Preferred Care and HealthAmerica, both managed care companies. Earlier in his career, Mr. Hertik was Assistant Administrator of the Saratoga Hospital. He began his career with Ernst & Ernst (now Ernst & Young) with a practice concentration in health care.

Mr. Hertik was a founding director of the Nashville Health Care Council, a trade group representing the interests of the many healthcare organizations headquartered in Nashville. In addition, he has served as a director of several successful healthcare companies including currently Athena Diagnostics, Inc., a provider of highly specialized genetic assays; and Tandem Healthcare, Inc., a regional provider of post-acute long-term care services.

Mr. Hertik is a Certified Public Accountant and holds a master's degree in accounting and a bachelor's degree in economics from the State University of New York.

Michael Bailey is President and Chief Operating Officer of Windsor Health Group, Inc. In this capacity he is responsible for the general management of Windsor's operations. Windsor currently owns and operates Windsor Health Plan of TN, a managed healthcare plan serving TennCare and Medicare Advantage enrollees; Windsor HomeCare Network, a specialty managed care company which organizes and manages networks of home healthcare providers; and 50 Plus Strategies, a financial services firm targeting the senior population.

Prior to joining Windsor Health Group, Mr. Bailey was Executive Vice President and Chief Operations Officer of Medsolutions, Inc., a specialty managed care company focused on radiology services, with responsibility for the operational aspects of the company's core businesses, including contract implementation, contract operations, claims, and provider relations. Before assuming the duties of COO, he was the Chief Financial Officer, managing all aspects of finance, acquisitions and development for the company.

Prior to forming MedSolutions, Mr. Bailey served as Executive Vice President, Chief Financial Officer of National Imaging Affiliates, Inc. ("NIA"). At NIA, Mr. Bailey managed all aspects of finance, acquisitions and development for the company, including banking and shareholder relations, information systems and new capital initiation. While at NIA, Mr. Bailey assisted in the acquisition of approximately $70 million in revenues and raised approximately $40 million in financing.

Before joining NIA, he served as Vice President, Chief Accounting Officer, and Corporate Controller of Coventry Corporation (now Coventry Health Care), a publicly traded managed care and insurance company. At Coventry, his responsibilities included SEC reporting, banking relations, internal financial reporting and participation in investor presentations.

Mr. Bailey began his financial and healthcare related career as a member of the audit staff of Deloitte and Touche for more than 10 years. He was involved in all levels of accounting, auditing and consulting services including initial public offerings, private and public debt offerings, mergers and acquisitions and leveraged buyouts. Virtually all of his clients were healthcare related.

A graduate in accounting from Austin Peay State University, Mr. Bailey is a Certified Public Accountant and a member of the American Institute of Certified Public Accountants.

Willis Jones is Executive Vice President and Chief Financial Officer of Windsor Health Group, Inc. In this capacity, Mr. Jones is responsible for managing all aspects of finance and financial analysis. Windsor currently owns and operates Windsor Health Plan of TN, a managed healthcare plan serving TennCare and Medicare Advantage enrollees; Windsor HomeCare Network, a specialty managed care company which organizes and manages networks of home healthcare providers; and 50 Plus Strategies, a financial services firm targeting the senior population.

Prior to joining Windsor Health Group, he served as Vice President of Finance and Corporate Controller of MedSolutions, Inc., a specialty managed care company focused on radiology services. At MedSolutions, Mr. Jones managed the finance, acquisitions and business development for the Company. His responsibilities included banking and investor relations, financial reporting and new capital initiation.

Prior to MedSolutions, Mr. Jones served as Vice President, Corporate Controller of National Imaging Affiliates, Inc. At National Imaging, Mr. Jones managed the finance function which included due diligence, budgeting process, accounting, banking relationships and accounts

receivable. While at NIA, Mr. Jones assisted in the acquisition of approximately $50 million in revenues and raised approximately $40 million in financing.

Mr. Jones began his financial and healthcare related career as a member of the audit staff of Deloitte & Touche. At Deloitte & Touche, he was involved with accounting, auditing and consulting services including public offerings and mergers and acquisitions.

A graduate of Middle Tennessee State University, Mr. Jones holds a Masters of Business Administration and Bachelor of Business Administration (Accounting) and is a Certified Public Accountant.

TennCare Reports	Frequency
Paid Claims Encounter Data	Weekly
Member Change Data (Address, etc)	Weekly
Top 25 Inpatient Diagnosis by Amount Paid	Quarterly
Top 25 Outpatient Diagnosis by # of Visits	Quarterly
Top 10 Inpatient Surgical/Maternity Procedure by Frequency	Quarterly
Top 10 Inpatient Surgical/Maternity Procedure by Amount Paid	Quarterly
Top 10 Outpatient Surgical/Maternity Procedure by Frequency	Quarterly
Top 10 Outpatient Surgical/Maternity Procedure by Amount Paid	Quarterly
Members Utilizing Out-of-Network Providers	Quarterly
Provider Enrollment (changes)	Monthly
Individual Encounter Reporting	Monthly
Reporting of Other Insurance	Monthly
Subrogation Recoveries Report (TPR)	Monthly
Check Run Detail	Weekly
Quarterly Activity Reporting (calls)	Quarterly
Weekly Claims Activity Reporting	Weekly
Quarterly Financial Form required by NAIC	Quarterly
Listing of Essential Hospital Providers in MCO Network	Annually
Listing of Specialty Physicians Arrangements	Annually
Medical Fund Target Monitoring Reports	Monthly
Report of all Complaints/Appeals for Title VI	Quarterly
Eligibility and Premium Reconciliation	Quarterly
Quarterly Member Newsletter	Quarterly
List of Requests for Translation or Interpreter Services	Quarterly
Claims Payment Accuracy	Quarterly
Bonus Calculation for TPL	Quarterly
Quality Management: Continuity of Care	Quarterly
EPSDT Monthly Summary Status	Monthly
EPSDT Quarterly Summary Status	Quarterly
Listing of Referral Providers	Quarterly
Provider Newsletter	Quarterly
Report of all Supervisory Personnel	Quarterly
Report of Grievance and Appeals	Quarterly
Top 25 Drugs by Class (Prescription Drug Summary)	Quarterly
Top 25 Providers by Amt Pd	Quarterly
Specialty Utilization by PCP	Quarterly
QM: Quarterly Focused Studies	Quarterly
Bonus Calculation for Single Source	Quarterly
Weekly Activity Reporting (calls)	Weekly
Annual List of CSA Non-Institutional Providers	Annually

TennCare Reports	Frequency
Copy of Policy concerning non-discrimination of members with Limited English	Annually
Annual Compliance Plan	Annually
Notification of EPSDT Screening Due	Annually
Utilization Review and Written Utilization Program for EQRO	Annually
Writing and Delegation of QMP	Annually
Member Handbook	Annually
Minimum of 6 Outreach Contacts per year for info concerning EPSDT	Annually
Third Party Pmt Recoveries	Annually
Performance Indicator Report	Annually
Quality Management: Continuously Focused Studies	Annually
QM/QI Program and Quality Monitoring Program	Annually
Demonstrate Meaningful Improvement (usually 10%) in EPSDT/Quality of Care Program	Annually
Assess Availability and Accessibility of Primary Care Svcs including 24 hour Access	Annually
Listing of all Policies that emphasize non-discrimination in employment and operations	Annually
FQHC Reporting	Annually
Annual Form Required by NAIC	Annually
Ownership and Financial Disclosure as stated in Contract	Annually
Audit of Business Transactions w/Audited Financial Statements	Annually
Top 25 Providers by Amount Paid	Quarterly
Cumulative Y-T-D Reports as defined in Attachment XII L1..L6	Quarterly
Members Utilizing Out-of-Network Providers	Quarterly
Members Abusing ER visits	Quarterly
High-Cost Claimants in excess of $25K per rolling quarter	Quarterly
Specialty Utilization by PCP - PCP Profiling	Quarterly
Out of Network Utilization - PCP Profiling	Quarterly
Emergency Room Utilization - PCP Profiling	Quarterly
Inpatient Admissions - PCP Profiling	Quarterly
Advanced Imaging Utilization - PCP Profiling	Quarterly
Pharmacy Utilization - PCP Profiling	Quarterly

Additional Medicare C and Medicare Part D Reports	Frequency
Enrollment/Disenrollment	Quarterly
Reversals	Quarterly
Medication Therapy Management Programs	Semi-Annually
Generic Dispensing Rate	Quarterly
Grievances	Quarterly
Prior Authorizations, Step Edits, Non-Formulary Exceptions, and Tier Exceptions	Quarterly
Appeals	Quarterly
Call Center Measures	Quarterly
Overpayment	Semi-Annually
Pharmaceutical Rebates, Discounts, and Other Price Concessions	Quarterly
Licensure and Solvency, Business Transactions and Financial Requirements	Quarterly

Advantage Behavioral Health Management Team

Debbie Cagle, CEO has over fifteen (15) years experience in the field of managed behavioral health care. Prior to her current role, Cagle served as chief operating officer of ValueOptions of Tennessee. Prior to that Cagle served as Vice President of AdvoCare of Tennessee, a subsidiary of Magellan Health Services, where she managed benefits, treatment services and care for 1.3 million TennCare enrollees, including 125,000 with severe mental illness. Additionally, Cagle directed behavioral health managed care contracting for HCA and Vanderbilt University Medical Center.

Cagle is well known and respected in the behavioral health managed care industry nationally. She is highly regarded by consumers, providers, advocates, various departments of State Government, and other major stakeholders in Tennessee. She has demonstrated her considerable abilities in successfully addressing complex issues fraught with financial, political, and consumer sensitivities. Cagle brings an extraordinary set of skills, experiences and knowledge to her position at Advantage.

Prior to joining Advantage Behavioral Health, **Sherry Harrison, Executive Vice President,** was a long term employee in Tennessee State Government. Harrison spent three (3) years (2000-2003) as the Director of Managed Care with the Tennessee Department of Mental Health and Developmental Disabilities where she oversaw and managed the TennCare Partners Program. Prior to that Harrison spent fifteen (15) years at the TennCare (Medicaid) Bureau where she held a variety of positions including Assistant Director of Policy and Director of Provider Services. During her tenure in State Government Harrison worked closely with the Department of Children Services, the Department of Commerce and Insurance, the Department of Health and the Attorney General's Office. Additionally, Harrison served as the Bureau's liaison with the TennCare Government Relations Committee and often appeared before the TennCare Oversight Committee.

Harrison remains keenly aware of the intricacies of State Government and sensitive to critical issues facing the State. Both Cagle and Harrison believe "there is a better way to do business". Together they bring fresh and innovative ideas to publicly funded managed behavioral health while recognizing the constraints of such programs.

Pete Biagioni serves as the **Chief Information Officer** for Advantage. Biagioni is responsible for the strategic and operations development and deployment of management information systems, products, services and technical infrastructure. He is committed to the advancement of technological capabilities by integrating new technologies and developing strategic alliances with leading technology pioneers.

Mr. Biagioni has over 20 years experience in the field of health care information systems and technology, 6 years at the Chief Information Officer level, 2 years as president of e-Health Internet technology development organizations, 4 years as CEO of a healthcare technology consulting organization, and 5 years managing in "Big 5" and national health care consulting practices. Biagioni is a nationally recognized leader in the healthcare field of management information. Biagioni's work in various states and programs has provided him with extensive knowledge about what information systems are needed and what works in large public programs as well as designing and implementing new technologies successfully.